# ATTACHMENT 2
# Sample Prior Authorization/Request Form (PA/RF) to be submitted with the Prior Authorization/Birth to 3 Therapy Attachment (PA/B3)

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 161

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Ima

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow St. Anytown, WI 55555

5 DATE OF BIRTH: MM/DD/YYYY

6 SEX: M ☐ F ☒

8 BILLING PROVIDER TELEPHONE NUMBER: ( XXX ) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
I.M. Billing
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.: 87654300

10 DX: PRIMARY: 783.4 Developmental delays

11 DX: SECONDARY:

12 START DATE OF SOI:

13 FIRST DATE RX:

| 14 PROCEDURE CODE | 15 MOD | 16 POS | 17 TOS | 18 DESCRIPTION OF SERVICE | 19 QR | 20 CHARGES |
|---|---|---|---|---|---|---|
| | OT | 4 | 1 | Birth to 3 OT services | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | TOTAL CHARGE | 21 |

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YYYY (DATE) 24 I.M. Provider (REQUESTING PROVIDER SIGNATURE) Start Date: MM/DD/YYYY

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

DO NOT write in this space.
Reserved for Medicaid use.

DATE — CONSULTANT/ANALYST SIGNATURE

482-120